Using Local Evaluation Data to Promote & Sustain Your Healthy Start Project (Webcast Date: July 29, 2003)

DAVID de la CRUZ: Hello, my name is David de la Cruz.
A senior program healthcare officer in the healthy start branch.
I'll be the moderator today.
Welcome to our second webcast.
Today's topic is using local evaluation data to promote and sustain your Healthy Start project.
Our speakers today will be Julie Wisniewski from the Worcester Healthy Start initiative and Goldie Watkins Bryant from the Central Harlem Healthy Start.
The speakers will discuss the variety of ways in which data have been used to describe the success of their programs.
It is the goal of this webcast to present you with ideas on how to more effectively use program information and data.
Before we begin, I'll remind you of a couple brief instructions on how to participate in this webcast.
Slides will appear in the central window and should advance automatically.
The slide changes are synchronized with the speaker's presentations.
You don't need to do anything to advance the slides.
Although you may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.
Also as opposed to the first webcast, this is an audio only webcast.
That is, you'll not see a video of the speakers but only hear our voices.
And see our slides.

We encourage you to ask the speakers questions at any time during the presentation.
Simply type your question in the white message window on the right of the interface, select question for speaker from the drop down menu, and hit send.
Please include your state or organization in your message so that we know where you are participating from.
The questions will be relayed on to the speakers periodically throughout this broadcast and we'll address them at the end of their speeches.
Again we encourage you to submit questions at any time during the broadcast.
A reminder, there will be no video for this webcast, just sound and slides.
At the end of the broadcast, the interface will close automatically and you'll have the ability to fill out an online evaluation.
Your responses to help us plan future broadcasts in the series and improve our technical support so please do that.
Each of the two speakers will have approximately 20 minutes for their presentations.
It will allow us to have plenty of time for feedback, questions, comments and suggestions submitted by you, our grantees.

Let's begin.

Our first speaker this afternoon is Julie Wisniewski.
She is the program director of the Worcester Healthy Start initiative and has been with the program since its inception in June of 2000.
She received her masters of public health degree from Boston University, concentrating in maternal and child health as well as nutrition.
Julie is an alumni board member of the school of public health Boston University, and a mentor to graduate students as well as prospective students.
Julie, it's all yours.

JULIE WISNIEWSKI: Thank you, David.
Today I'm going to be talking about ways to maximize the power of data and in particular how Worcester, Massachusetts, their Healthy Start initiative is using data for sustaining achievability.
Our lead agency is the great Brooks valley health center, one of the two community health centers in Worcester, Massachusetts.
We have three main overall objectives.
To decrease the infant mortality rate through the creation of a system that guarantees 100% access and zero disparities in healthcare to implement a universal screening using risk assessment model for pre-natal care and create and institutionalize permanent changes in the system of care.
Our program is citywide.

We have 12 case managers who are located at a total of five different sites throughout the city.
So no matter where a woman is getting her pre-natal care, we have arranged so that a case manager can work with her.
Two community health centers are involved including our lead agency, great brook valley health center as well as a hospital.
And then the case managers at the two other sites work with patients from private providers.
The case managers are funded from various sources, about half of them receive direct funding from the Healthy Start initiative grant and the other half from state-funded grants as well as local grants.
Every trimester during pregnancy the case manager conducts a psycho socio risk assessment with every patient and a risk assessment related to infant health and care and postpartum health during the postpartum period.
All of that information is then collected by the case manager at the time of the visit, written down and submitted to Healthy Start and we do the data entry and then analyze all of the data also as we get it.
So it's a very concurrent system of as the encounters are done.
Case managers collect the data, get it into Healthy Start and we analyze it.
I'll talk more about that in a minute.

Then we provide services based on the risks or needs identified during assessments and follow up and I'm sure you can see the list of services there and I'm sure that's very similar to a lot of other programs.

So I alluded to the fact that it's important that we are gathering data as we do the visits or as the case managers do the visits, they get it in to us.
We want to be able to make prompt decisions about when we need to intervene or how we need to intervene.

Responses must also involve evaluation and that enables us to shift gears according to where we identified what is working and what's not working.
And then our interventions we always want to base them on proven models whether it's best practices or also looking at what other agencies are doing, what is working.
A quick example of that is at times we've had some difficulty making sure that the case managers are able to do all of the post-partum encounters with their participants.
And so we notice that by looking at the data as it was coming in.
Yet we also noticed one of our sites was doing a good job meeting our objectives so we looked more closely to see why was one of our sites doing well, succeeding and how can we learn from that and apply their model to our other sites.

As you're aware.
We feel the infant mortality problem has a great deal of urgency to it and that requires we give an urgent response but we don't want our responses to be hap hazard or knee jerk but we always rely on evaluation.
There are many, many, many important uses for data that can benefit all of our programs and certainly I am just here representing one of our programs.
I'm sure all of the rest of you and certainly Ms. Watkins Bryant will share many of her ideas, too.
Email in during the webcast your ideas of how you're using data to benefit programs.

And I want to say that first and foremost certainly we use our data to determine what we need to do for interventions for our participants.
We check out, see what their needs are, their risks and that determines how we intervene.
We also look at sort of the patterns of risks that we're seeing through the data and then we can see where we need to place more emphasis in our case management interventions.
So that aside, now I'm going to look more at other uses for the data to benefit our program.
And I'll briefly mention all these bullet points and go a little more in depth into each one in just a minute.
We use data to make sure that our case managers see the big picture, that they stay motivated.
No what they're doing it and why they're doing it and it's worthwhile.
We use our data to get other funding.

To report to the community consortium and explain the infant mortality problem to other medical and social service providers to get their support and involvement.
And we educate the community and enlist their support.
We use data to convince the media to continue to cover the issue of infant mortality.

And we also map data to assess geographic trends.
We share our data with other Cities to help them address their problem of infant mortality and we use it to make convincing arguments for institutionalization.
We can use our data to educate, Medicaid or other insurers about the importance of case management and reimbursement of case management.
So looking at how do we use data to make sure that case managers see the big picture?
They workday in, day out very hard working with patients one-on-one and it's very easy to get caught up in that and not necessarily know that overall city-wide that they're making a difference.
Certainly they see they're making a positive difference in individual lives but it helps them to keep in perspective the importance of what they're doing and the importance of making sure that they are collecting and giving to us accurate and complete data if we show that all their hard work is paying off.
For example, you can see the graph on this chart.
We are seeing -- this is one example for one year but it is a trend over the years.
We've had our healthy start funding, that in the year 2001 single births for Healthy Start initiative births.
1% of those births were very low birth rate and pretty comparable to all the births in Massachusetts that year.
It compares to all of Worcester that same year which was 1.5%.
Worcester Healthy Start initiative participants are a sub group of all Worcester births.

We need to make sure the case managers are aware of this type of thing.
Our lead agency, great brook valley health center, has also actually statistically significantly lower percentages of low birth weight among their patients compared to all births in Worcester and the Massachusetts births.
The health center has always been using this case management model.
We believe this is very important.
The case managers need to see it is very important.
We can also show the case managers that the percent of patients, for example, who smoke when they enroll in the program, they're pregnant, that is a higher percent compared to the percent of patients who are smoking in their third trimester.

It is showing the work the case manager does with those patients to say this is dangerous, the tobacco is harming your fetus, here are ways you can try to cut back on smoking or quit, that's paying off and we've had wonderful positive feedback from the case managers when we talk to them about that.
The next slide is talking about something that is probably extremely obvious. I'm sure that all of you are already aware of it but it's worth mentioning that data is absolutely essential for obtaining additional funding.
There are certainly immediate benefits of just having additional monies to do more with.
It's essential to have data to prove the need for more funding to make a convincing argument that shows how, say, Worcester Healthy Start initiative participants are doing better than the city population so we need more money to reach more people and have a bigger impact on the city.
In addition, Worcester Healthy Start initiative has directly received funding from a local foundation as well as the March of dimes for additional case managers, outreach workers, additional projects like healthy beginnings pregnancy.
We know from talking to those grantors it was our data we were able to prove the need and show that we have the model set up right that they were willing to trust us and give us the money so that we can try to do more.
There are also long-term benefits of obtaining support beyond the Healthy Start initiative funding and also it's extremely beneficial to collaborate with other departments or other agencies to help them obtain funding because if we're able to use our data to support the need for them to get more funding, let's say for case managers for other services that our participants can benefit from that certainly ends up benefiting the Healthy Start initiative as well.
And we have been successful at the health center working in collaboration with Healthy Start data and so forth has received an Office of minority health grant for a case manager and also a local grant for a Portuguese speaking case manager.

On a quarterly basis I make a data report to the community consortium and this data is very helpful for the consortium to make informed recommendations about the direction of the Healthy Start program.
The consortium can then use its influence in the city to get other organizations, other leaders to buy into our Healthy Start initiative model.
This includes to convince agencies to institutionalize the model for the long term.
We're also using our data to help explain the infant mortality problem in Worcester to other medical and social service providers to get their support and involvement.
One example is because of our ongoing extensive data connection we've been able to earn the respect of two physicians in the city who have also been collecting data on poor birth outcomes and we now work in collaboration.

We're much more able to have better progress, make better progress on reducing infant mortality by working together versus just this sum total of our individual efforts.
Black, non-Hispanics in Worcester have had about 4 1/2 times the infant mortality rate compared to white non-Hispanics and Hispanics.
The physician on our consortium in charge of the neonatal intensive care unit saying he was seeing more and more African immigrant families.
It led us to examine the birth data over times for black births and the mother's country of origin.

Worcester's African population.
It led us to the early recognition that our black population in Worcester is changing.
It's not just African-Americans, it is now also to a large extent African immigrants.
This requires that we learn what the issues are that are facing this population in Worcester and that I may be involved in their high proportion of poor birth outcomes.
We can't just rely on using the data from the census which is every ten years.
First of all because of the time lag and these changes occur in a much shorter period of time.
But also because we want to be sure to know about how many, roughly, undocumented immigrants there are so we can provide services, much-needed services to them.
We are able, through the neonatal intensive care unit looking at the student population demographics in the schools, looking at our participant demographics, better able to estimate the number of undocumented immigrants in our area.

So overall we must continuously collect and analyze data to be able to respond in a timely fashion to the changing needs of our community.
We also have been using our data in -- in response to looking at the changing demographics to show the pastors of African American and African immigrant churches the racial disparities in outcomes.
It wasn't until we were analyzing black infant mortality rates right prior to our funding of Healthy Start. They looked at these rates with using three year and five-year rolling averages and that was how they were able to see that there is a disparity in the health outcomes.
Not just a basic disparity but an alarming disparity.
As large and sometimes larger than that of Boston.
Certainly Boston has had much attention and been working on their health disparity for quite a while now.
So because we have a small black population in Worcester and our data oftentimes there were fewer than 500 black births or fewer than five infant deaths in a year the numbers were too small to be able to analyze on a yearly basis.

So that's why it was so important to look at three-year averages and rolling averages.

Now, realizing black infant mortality is so high, we looked at the problem various ways to -- we wanted to find how to access the community to work with them on the problem.
We found that churches are the best way to reach the black community.
It has really only been in the past few years that the black community as well as most other people in general were aware that infant mortality was a problem, let alone such a huge problem for Blacks in Worcester.
It's essential to work with the pastors first in order to gain access to their population.
We had to show with numbers and show them that we are doing something to start to address the problem.
Once we've been able to assure the pastors of that often they say how can I help and how can I work with you on this?
So they buying into our Healthy Start model is essential.
One thing we want to do is working with a community is start up a black women's groups or multiple black women's groups in the churches and work with those already established to focus on infant mortality.
Worcester Healthy Start initiative needs to train and educate in the women in the groups using the data and have them reach out, support and educate perinatal women in their community.
These groups exist longer than Worcester Healthy Start initiative.
How do we keep the issue right in the forefront of the public's awareness?
We need to make sure the media continues to cover the issue.
The media's argument is that well, infant mortality has been a problem in Worcester for decades.

This is old news.
Why should we cover it?
Even though it has been a problem for decades in our city we need media coverage to show what changes are occurring, both the good changes, the Healthy Start initiative and the community are able to do and succeeding in but also bad changes.
We need the community to realize that some of our African immigrants are also having difficulties with poor birth outcomes.
We need it to be in the news.
The importance of increasing the public awareness is that we need to recruit more people from the community to be involved as participants and also on our community consortium.
The next slide shows a map of Worcester.
This is an example of how we're doing small area analysis.
It is one approach to take to assess what some of the issues may be and look for patterns over time.
The map of Worcester is broken down into areas we call census tracts.

We saw that over time these pink areas consistently kept having high infant mortality rates.
So that was a trend that we saw.
Then we realized that in these areas that is where most of our low-income residents are living.
That led us to look further into psychosocial conditions affecting low-income residents such as housing crisis, stress of poverty.
Low level of education and how that's impacting infant mortality rates.
Other Cities have been asking us to share our data with them to help them in their process of trying to address infant mortality in their city.
Our showing them -- showing them our data we're able to show them the problem we've been facing, what we've been doing about it, how we've been successful so far as well as where we plan to direct our future efforts.
>From that little list of bulleted items you can see my overall theme here of that's how we go about using our date why in general and we recommend that others think about looking at their data for these purposes as well.
So given the many budget -- state budget cuts we've been facing.
I know it's not just Massachusetts that has been having a problem with this.
We cannot just rely on obtaining more money or more grants for sustainability.
We must institutionalize the healthy start initiative model.
We must also show data that shows the model's success and that ultimately it could save money.

Currently as I mentioned, we've been using grant money to cover the cost of case management and it's usually small monies.
These are usually time-limited grants, function specific and often too little money to be able to fully address a problem.
Philanthropy wants to fund no projects and doesn't want to renew grants and they want us to sort of deal with the problem and solve it in one year.
There is a different patient population every year so we can't sort of fix the problem in one year and stop providing the service.
So we need to look at how can we use our data to try to convince Medicaid and other insurers to make case management a wrap around service.
Right now, for a while, the federal Medicaid has mandated that all costs for care should be reimbursed for federally qualified health centers.
Medicaid is supposed to pay for wrap around services and in fact the state does have a certain amount of money that they use to reimburse these health centers for services such as health education, nutrition, case management.
It does not cover the full cost of what the patients need.
Think about our high-risk clients.

An HIV positive woman needs to meet with many providers and now we can only bill for one encounter per day for Medicaid.
Some organizations deal with the problem by having patients come on different days for different appointments.
It causes major access barriers.

Because of the complexity of our clients we need to make sure we're getting an actual amount of reimbursement important the actual cost of services.
So how do we do that?
Well, we can try to encourage the federal government, one idea at any rate, to call states to be accountable to fully reimburse for actual services and we also need to think about the fact that we're trying to institutionalize the service.
First ideally we would like to get reimbursed for the services but we need to know what the cost will be in order to institutionalize our model.
Another idea or possible approach could be related to Medicaid managed care and have mandated retainment of three years commitment.

The problem right now is that people every six months have to go up for re-eligibility.
We know that pregnant women need health insurance throughout their pregnancy, nine months, as well as for multiple years post partum in order to optimize birth outcomes and their health.
We want a structured set of required services, parenting skills, women's health issues.
We know that's what we're doing at Healthy Start. How do we get this to be mandated for insurance coverage and reimbursement?
One of the pluses of a mandated managed care program is that it provides the capacity to evaluate the quality of care.
And again we also know how important that is to do.
So we could try to convince Medicaid managed care to allow people in for three years of fully comprehensive care and structured services.
As you can see there are many ways programs can use their data to work towards sustainability from getting the community involved, obtaining additional grant funding to finding ways to educate insurers to get reimbursement for the cost of services such as case management.
I would like to tie things up there.
The second to the last slide shows our funders.
We're thankful and grateful for the Maternal and Child Health Bureau funding of Healthy Start and the Worcester greater community foundation and the March of dimes.
After Ms. Watkins-Bryant speaks, we'll ask questions.
Feel free to contact me at any time.

DAVID de la CRUZ: Before I introduce and give a little background information on Goldie Watkins Bryant I do want to emphasize what Julie just ended with.
We do encourage you to ask questions to any of the participants on the webcast, ask questions.
Type your question in the white message window of the right of the interface, select question from speaker from the drop down menu and hit send.
We'll be taking those questions or comments at the end of this presentation.
So now onto our next speaker.

Goldie Watkins Bryant came to New York City in 1979 as deputy director of the New York City regional office of the New York State Department of Health.
She used her many years of public administration with the Department of Health in managing the Healthy Start New York City program from 1998 to 2001.
She was responsible for raising approximately $16 million for the project and managing three subcontracts for the provision of case management, outreach and health education services focused on improving Maternal and Child Health Bureau in Central Harlem, south Bronx and central Brooklyn.
She's director for the Central Harlem Healthy Start. Goldie.

GOLDIE WATKINS BRYANT: Thank you, David.
The Central Harlem Healthy Start project is just one of the programs sponsored by the partnership.
It's a freestanding community based agencies that sponsor other perinatal case management programs.
A high-risk perinatal outreach program.
A foster care placement prevention program and a head start program among several others.
The Central Harlem Healthy Start projects was one of the original Healthy Start projects initiating services in 1991 with medical and health research association as the grantee.
Since the fall of 2001, Central Harlem Healthy Start has been managed by northern Manhattan perinatal partnership.
Our staff consists of various case managers.
We have clients from west Africa, including Senegal and the ivory coast.
With the French speaking and spoon I shall speaking case managers we're able to target two of our high risk communities.

We have a case management supervisor, an African-American outreach worker and a young woman from the Dominican Republic.
He have two managers.
These individuals are supported by an M.I.S. manager, an administrative assistant and receptionist data entry person.
I will talk generally about how we have used data both in fundraising and in managing our project.
Slide one, please.
When we think of the power of data, -- when we think of the power of data to get our attention and move us to action, we necessarily look to the origins of the national Healthy Start initiative in 1990.
International data on infant mortality by county revealed -- country revealed that the United States ranked 28th among industrialized countries in infant survival rates.
Even Cuba could point to a better infant survival rate than the United States.
This information gave Dr. Lewis Sullivan.

The secretary of the Health and Human Services administration the leverage he needed to convince president George W. Bush senior to undertake the healthy start initiatives.
Communities with infant death rates that were at least twice the national average of 12 infant deaths per 1,000 live births at that time were encouraged to apply for funds.
As many of us have discovered, communities with infant mortality rates of 24 or more are generally urban, rural, consist of Indian reservations.
Residents of these communities in too many instances have grown to accept sick and dying babies as the norm.
While their attention was focused on securing adequate food, safe housing and employment.
When we first asked Harlem residents in 1990 about their priorities, jobs were the number one issue.
As we have been able to include G.E.D. preparation and computer training among the services we offer, we have been more successful in retaining former case management client involvement in our consortium and other Healthy Start activities.

Moreover, as we've educated our Healthy Start initiative community residents that there are many activities that can be undertaken to improve birth outcomes, they have become their own best advocates for funding and for improvements in Maternal and Child health.
We now have Central Harlem healthy start families who speak out about infant mortality in radio and TV news features, who participate in press conferences and who tell their stories to our elected local, state and federal officials.
And indeed, it was our excessive infant mortality rate which was used in various newspaper that facilitated our efforts in educating our elected officials.
In spite of the severe budget crisis in New York City, advocates, consumers, providers and former clients have succeeded in getting the New York City council and our mayor to set aside $5 million to fight infant mortality for the third straight year.
The individuals that you see -- the names of the individuals on the screen are our city council individuals.
Mr. Perkins is the representative from Central Harlem.
These $5 million are not exclusively for the use of Central Harlem Healthy Start. But will be used by perinatal agencies across the city where there are excess pockets of infant mortality.

In respect we have successfully raised $15 million for community-based activities to improve birth outcomes in New York City since 2001.
Although the infant mortality rate for Central Harlem has decreased by more than 50% since we initially received Healthy Start funds in 1990, that is dropping from 27.7 infant deaths per thousand live births to 13.1 our infant mortality rate continues to be the highest in the city.

This fact has served as a rallying point for our legislative education and fundraising efforts.
Data was crucial to our success.
We are all familiar with the use of data to guide program design.
We have been looking at what's happening in our communities vis-a-vis infant mortality.

We do an analysis to see whether or not low income community residents, teen births, births to people of color, older women or substance abuser, formerly incarcerated are driving our infant mortality rate.
As they look at the analysis we know where to focus our outreach activities.
How to engage the intensity of our case management services and we know the kinds of providers we will need to engage as partners.
Our potential client base also dictates the nature and focus of our health education activities.
Moreover, community surveys will inform the approach we must take to engaging community residents to create and contain a strong consortium.
The meet community needs.
Our community residents most concerned about safe and wholesome food, safe housing, employment?

By conducting surveys to find out the community's concerns, then you can create programs to address what bothers them most.
As northern Manhattan perinatal partnership added programs to help people get their G.E.D. and learn to operate various computer programs in job settings, helping our clients to secure better paying jobs and more secure jobs, we increased the community's buy-in to working with our consortium to improve birth outcomes.
The logic model proved very helpful in terms of us designing our program.
We were able to look at the demographic data available in terms of the characteristics of our residents in Central Harlem.
We were able to look at other health and related community interventions provided by our own agency that could support our work and we looked at our existing organizational relationships that we could build and strengthen on in services to our clients and enhancing commitment to our consortium efforts.
All this information was used in designing our Healthy Start and delineating our goals and objectives.
After outlining what we hoped to achieve during the Healthy Start initiative period we then knew the data we needed to collect annually to tell us whether or not we were on track for improving the health and well-being of mothers and newborns in our targeted zip codes.
As we implemented our plan, critical data had to be collected.
Process data helped us evaluate our implementation design and outcome data helped us measure our impact.
Are our out reach efforts bringing in clients during their first trimester of pregnancy?

Are clients keeping pre-natal appointments?
It's the data we collect on pre-term delivery.
Infant birth rate and the infant mortality rate within our client base.
Ideally processed data should be collected weekly, summarized monthly and compared with annual process objectives every two months or at the least quarterly.

Data collection instruments must be designed for outreach, case management, health education, and consortium building activities.
Process data such as some of the data collected weekly by our case managers is used to tell us if we're doing what we set out to accomplish.
Staff will always resist data collection requirements in the interest of providing services.
However, by making the data collection tools simple and providing frequent reports back to staff on how they are doing, you enhance data collection effectiveness.
In addition to using the data you collect for accessing program -- assessing program implementation it should also be used for examining the quality of your activities.
You want to evaluate carefully each component of your program beginning with your outreach activities.
Are outreach materials designed with culture all sensitivity and engaging colors and messages?
Are the targeted zip codes the focus of canvassing efforts?
Are outreach materials posted in the most effective venues?
Beauty parlors, Laundromats.
The data you collect on your clients, do they call you because of a flyer in the community.
A recommendation from a former client or a friend who heard about the program?

This information will help you update your outreach plan each year.
In addition to referral source, what are the zip codes of clients and what are their risk factors?
Answers to these questions tell you about the effectiveness of your outreach activities.
Moreover, comparing your client base with the originality indicator data will tell you whether or not you're reaching your targeted audience.
If you're not, you will learn how to shift your activities to be more effective as you regularly update that outreach plan.
For case management activities, do service plans reflect clients' needs?
Are referrals to services made on a timely basis?
Are clients actually receiving needed services?
Are the services being received making a difference?
To assess the effectiveness and the impact of your case management program, requires the collection of an enormous amount of data.

However, the feedback you receive on client utilization of services, behavior change, birth outcomes and immunization status of infants supports continued quality improvement of your various activities.
In terms of health education, these activities have to be effective on several levels.

You must raise the community's awareness about the problem and the community's role in doing something about it.
You have to educate stakeholders, your ministers, civic leaders and educational leaders on the problem and the role each group can play in supporting women and improving their overall health and well-being.
And encouraging partners to participate during the pregnancy and in support of the newborn.
The education of your clients in self-care and family care is very important.
This extends to behavior modification around smoking and substance abuse.
Good nutrition habits and keeping pre-natal, postpartum and pediatric appointments and your case management data that you've collected will help speak to the effectiveness of these efforts.
Each of these responsibilities on the part of the health education program must be evaluated on an ongoing basis.
Are your education efforts effective in transmitting needed information?
Responding to outstanding questions and impacting behavior modification?
All data that needs to be collected so that you have a continuous feedback loop on how well you're doing with those efforts.
Then when we look at our consortium building activities, for all of the Healthy Start projects they have posed our biggest challenge.
By definition, our projects are situated in communities where the day-to-day demands on residents are enormous.
The poverty and unemployment rates are high.
Homelessness rates are high.
Affordable housing is becoming less and less available.
Personal safety continues to haunt residents and many partners are unemployed or are incarcerated so the distractions are many.
We have found former clients for the assistance they have received and want to give back.

There are residents, stakeholders and advocates who care deeply about infant health as well as maternal and family health.
Who are willing to work with you to improve the community's health status.
As you reach out to these individuals, initially one-on-one or in small groups, giving them the data that you have collected on what is going on in your community, you begin to build a sense of what specifically interests them around improving the community's maternal and child health status.
You then fashion activities, seminars, workshops, newsletters, health fairs, etcetera, to engage community residents.
Lastly, your consortium is your key to project sustainability.

At least the health education, community mobilization and resource development components.
With our Central Harlem Healthy Start consortium, we have several committees.
Those focusing on each program element, outreach, case management and health education.

And those focusing on groups we want to engage such as our male involvement consortium and our consumer involvement organization.
Our public health committee focuses on rallying the community, other providers and advocates to assist us in educating our elected officials on the importance of improving maternal and child health.
Lastly we're in the process of establishing a resource development committee to concentrate on the sustainability of our Healthy Start project.
The chairs of each of these groups make up our steering committee.
The data that must be collected to assess your consortium building efforts includes participation rates, periodic surveys of the interests of participants and finally evaluation of the satisfaction participants feel in their role in guiding the local Healthy Start project in deliver its services as well as their satisfaction with the information received during meetings on maternal and child health.
You also want to collect data on the participate rates of community residents and activities sponsored by the consortium.
Job fairs, workshops, whatever, all of these components go into evaluating the growth and impact of your consortium.
As you can see, data is the driving force behind what we do and achieve.
The ultimate challenge is to collect no more than is needed to assure that we are meeting our goals and objectives.
We at Central Harlem have the benefit of an experienced evaluation manager, who has designed data collection forms for each component of our Healthy Start initiative and is currently working with our when MIS consultant to insure the case management data we collect will help us meet our new HRSA reporting requirements.

Each of you have received copies of our weekly data collection instruments and our program monitoring tool used to summarize the weekly data quarterly.
Feel free to use these data collection instruments as you see fit.
You have our email address and send us any questions that you might have as you review these instruments and have an interest in using any of them.
With that, I thank you for your patience and I look forward to any questions that you have in terms of what we here at Central Harlem Healthy Start are doing to reach our goals in improving Maternal and Child health in this community.
Thank you.

DAVID de la CRUZ: We do have several questions.

It's not too late to continue to ask more.
First a simple one for Goldie.
In your first slide you had the infant mortality rate for the U.S. at 7.2.
Just to confirm that's per 1,000 live births?

GOLDIE WATKINS BRYANT: That is correct, thank you.

DAVID de la CRUZ: Another question for both of you is what is the average caseload of your project?

GOLDIE WATKINS BRYANT: For us our case managers manage on the average 25 clients.
Those include some very high-risk clients as well as some very moderate-risk clients or relatively moderate risk.
On the average it's about 25.

JULIE WISNIEWSKI: For Worcester Healthy Start initiative our case managers have a very large caseload.
I would say there are about 30 moderate to high-risk women and certainly their risk changes at various times throughout the pregnancy based on what is going on in their lives plus other lower risk patients.
The priority is always on putting in the extra time for the high-risk clients, the supervisors for each case manager work very closely with them in order to be able to make sure they're able to provide the quality services needed for their large caseload.

DAVID de la CRUZ: Okay, great.
Another question, next question for both of you.
Have you developed a way to identify costs and benefits of Healthy Start services?
Sort of a cost and benefit analysis.
Or related to that, what are the variables that were used when you did a cost benefit analysis?

JULIE WISNIEWSKI: A Worcester Healthy Start initiative has not formally done such a cost benefit analysis and that is something that I am interested in also learning more about.
Possibly maybe even if there are enough people interested there could be a workshop or something at the conference about it.
Because I think it's really key.
One approach for other cost benefit analyses done at our health center is looking at how we've reduced the emergency room visits for patients of our health center and that has been helpful.
Now certainly we need to find something comparable to look at Healthy Start issues.
Goldie, did you have something?

GOLDIE WATKINS BRYANT: We haven't done a cost benefit analysis as yet either.
That is something that certainly would be of interest particularly as we look to Medicaid taking on the cost of case management services.
What we have looked at is the birth outcomes relative to the larger community.
And based on those birth outcomes we could begin to talk about the benefits of the program, particularly in terms of our minimal number of low birth weight infants.
We don't have nearly as many low birth weight infants as the rate -- as the rate in our larger community.

DAVID de la CRUZ: Actually we have -- we were hoping to have a third speaker on this webcast, Dr. Lauishi who was the local evaluator for a couple of the South Carolina projects he's moved up to the Baltimore area. He's currently working on a paper that does a cost benefit analysis, I think specifically preventing teenage pregnancies.
So when that paper is released, we do plan on sharing it with all the projects and we also have had very preliminary discussions with him to actually do a presentation at the grantee meeting if not just for his results but also for how he went about getting the data that he used.
Hopefully we'll have more information about that in the future.
It does seem to be some interest.
The next question is, how have you used your data at the policy level?
That is to influence policy makers and to educate politicians?

GOLDIE WATKINS BRYANT: Well, we haven't been particularly impacting in terms of using our unintended pregnancy outcome data from Healthy Start phase 2 in supporting the passage of what we called here in New York a family health plus where we provide the state -- the state uses its Medicaid funds to expand family coverage, family health insurance coverage for modest sums.
It works very much like child health plus but it's for the parents of low-income children.
And with the data on unintended pregnancies of low-income residents we were able to help educate our elected officials on the importance of extending family health plus that includes family planning services to those residents.

JULIE WISNIEWSKI: We have been working more in terms of educating our elected officials about the services we provide but also the services that we refer our participant to that are in the process of facing state budget cuts such as home visiting programs, school-based health centers.
We do not in Worcester healthy start initiative we do not receive any funding from the state or the city Department of public health, unfortunately.
Maybe at some point that will change.

But at this point it has remained more at the educational level and supporting additional programs.

GOLDIE WATKINS BRYANT: David, let me just add that we've just learned earlier this year that our maternal mortality rate here in Central Harlem is almost seven times the city-wide rate and so Central Harlem Healthy Start has been invited by the city health department.
They've used that data in terms of pulling together a working group that covers a larger community.
The larger Central Harlem community, much bigger than the zip codes we target.
They've developed work groups to come up with program ideas and initiatives to begin to address this whole issue of excess maternal death as well as infant death in our community.

DAVID de la CRUZ: Great.
Okay.
Have either of you used the data to receive financial awards or grants from other sources besides the federal government?
I think Julie you mentioned a couple in your presentation.
Anything else you can share about that?

GOLDIE WATKINS BRYANT: Julie, you can go first and I'll remind the group of our efforts.

JULIE WISNIEWSKI: Okay.
I covered most of it.
Certainly March of dimes and then local foundation has made a huge impact being able to use our data to get additional funding.
And we also know that other local foundations, other agencies have been able to receive funding because we collaborate with them and we share the data.
I mean, whenever someone is writing a grant in the area -- not whenever, but oftentimes people call us to get our data because we have the most complete data in the area about infant mortality and Maternal and Child health so it has been helpful.

GOLDIE WATKINS BRYANT: In terms of our success in the $5 million we've been able to raise over the past three years, $5 million each year through our city council, it was certainly the excess infant deaths in Central Harlem that drove our communities that have these -- not only Central Harlem but other communities in the city to put forth a special effort to educate the city council members on what was going on in these communities and to advocate for additional funds to help address the problem.
And so that data drove that effort and I would say the data plus the -- our clients, our data and our efforts were successful in generating $15 million over the past three years.

DAVID de la CRUZ: Thank you.
Have you developed marketing materials that support, advertise or publish your data result.
If so, are they copyrighted or can they be shared with the rest of the Healthy Start projects?

JULIE WISNIEWSKI: Our marketing materials, the majority of them are for our customers.
We don't want to use a lot of numbers in them.
We want them to be user friendly.
We know our target population in general has a relatively low reading level.
We do have marketing materials for physicians who we are trying to convince to refer their patients to us.
Those have some of the basic statistics, but we do not -- we have not published any of our materials in terms of marketing and advertising materials, so it's more of we just -- we create packets and presentations that are specific for the need with our more complex data.

GOLDIE WATKINS BRYANT: I would say we do the same thing with our depression of screening initiative we created data packets for the providers and so based on what we're undertaking, we tailor a package for the meeting. We take the data and incorporate it with other information that is appropriate forgetting the results from the meeting that we desire.

DAVID de la CRUZ: Depends on who your audience is.

GOLDIE WATKINS BRYANT: Exactly.
We tailor the handouts?

DAVID de la CRUZ: The sample weekly collection tool that you mentioned and talked about and sent out earlier looked very useful.
Is this copyrighted material?

GOLDIE WATKINS BRYANT: No, that's why we've E-mailed all of those weekly data collection unit to all the projects along with our program monitoring tool that we use the compile the data on a quarterly basis.
Since it is part of an attachment they can utilize it as is and work with it to change it if they want to, you know, modify it to meet their needs.

DAVID de la CRUZ: That's what you sent out this morning on the list serve.
What are some specific strategies for involving the community in using the Healthy Start data?
Not just the consortium members, but also the community.

GOLDIE WATKINS BRYANT: With the community workshops we have held, we have focused on the disparities.
That grips people.
That gets peoples' attention when you say women in this community are dying from childbirth at seven times the rate of women across the city.
Or that infants are dying in this community at twice the rate of infants across the city.
People tend to think that what is happening to them is happening to everyone.
But when they learn that a, they are at greater risk and b, there is something that can be done about it that's when we've been most successful in engaging community support.

JULIE WISNIEWSKI: Similar for Worcester Healthy Start initiative.
If it's a lay group we tend to do one blown-up chart showing the disparity in infant mortality rates and using colors to indicate the disparity and so forth.
Sometimes that helps.
Then you follow it up by having a tiny little Teddy bear that has one of those preemy diapers on it and you can pass that around.
You have the data there, they realize this is actual data but then they have the thing that grips them of how tiny this little diaper is and it's how small a very low birth weight baby is and so forth.
So yes, we use the data.
Then if we're talking to people who want more of the information, that's where the data packets come in using more charts and graphs.
We try to be very visual and straightforward and talk through more of the details.
That's our approach to the community.

DAVID de la CRUZ: And how have you used data to develop materials to share or educate private physicians?
You've talked a little bit about the community and some consortium members and some community-based organizations but how about the local private physicians?
Have you done anything specifically for them?

GOLDIE WATKINS BRYANT: We're currently working on hosting a grand round for the OB's at Harlem hospital to talk more about domestic violence and its impact on depression and the resulting impact on clients following the doctor's recommendations for maintaining themselves and their children.
So we're working on that as we speak.
And have not fleshed out what exactly we will share with them but there will be a considerable amount of data in the packet because physicians like data.

JULIE WISNIEWSKI: And we use grand rounds as opportunities as well as smaller sort of department-specific meetings at hospitals for the OB/GYN.

It is one of our task force members who uses the data he collects as well as the data from Healthy Start initiative to do these presentations.
We have found that much more effective the physicians are much more likely to listen if another physician is presenting the information.
It's Healthy Start information, the bulk of it but it's a physician on our consortium who presents it.
For the nurses there is also a nurse involved in our consortium and she does the presentations using our data as well.
We're collaborating with other health professionals who then share the information with their colleagues.

DAVID de la CRUZ: That actually kind of leads into the next question.
Other than data collection, what activities have your consortium members been involved in that have assured sustainability?

JULIE WISNIEWSKI: Because we share the data with the consortium and they're members of various agencies as well as general community members, they are going out and using the data to try to obtain additional funding through their institutions and that can lead to institutionalization of our model.
Many of those agencies have subcontracts with us.
I think that's one of the leading ways that they're using it right now that I can think of.

DAVID de la CRUZ: How about other than data collection?
What other ways do you use sort of broadening discussion a little bit, how else do consortium members help with sustainability?

GOLDIE WATKINS BRYANT: we're doing a couple of things that we're not sure how they'll impact in the long run.
But with our committee structure in the consortium we are bringing in other providers.
For example with our case management committee we're bringing in the case management supervisors from other programs that exist in the -- in our community that are longstanding programs.
Along with some of our clients to talk about some of our challenges in case management.
Have them actually buy into our program.
We're doing the same thing with health educators from other agencies to have them buy in.
Hopefully through that committee structure the committees will continue with the consortium should the Healthy Start project cease so you'll have some health education going on, resource development going on and these various activities taking place.
In addition we're working on a birthing center in conjunction with Harlem hospital and it was developed base on one of our earlier surveys of our clients in terms of resources that were available to them.

And many of our clients wanted the same kind of low-tech birth center available in this community as is available in other communities in the city.
And so we have worked with Harlem hospital over the past seven years, as it's turned off and that birthing center will be open this fall with full birthing suites.
It includes our -- oh, our nurse -- not our nurses but our -- our midwives, nurse midwives providing continuity of care at the community level and delivering those clients in our birthing center.

DAVID de la CRUZ: Great.
Next question is, some other entities, whether they be community-based organizations or agencies or some other groups have sometimes viewed Healthy Start as competition.
How have you used data to show that we're all in this together?

GOLDIE WATKINS BRYANT: We are providing a service in central Harlem that no one else is providing.
Those that are providing it don't have enough resources to meet all the needs of our high-risk clients in this community.
So we compliment the case management services provided by other institutions.
They don't see us as competitors.
And then we have the advantage of collecting this enormous amount of data both at the national, state and city level that we can share with them.
For some reason they don't seem to have access to this kind of data or they don't seem to know where to get it.
And so we compliment what they do and also help inform them about the impact of what they're doing.

JULIE WISNIEWSKI: For the most part our services also compliment the other agencies' services.
Before Healthy Start funding only a few agencies were providing similar services.
What we did we were able to then fund other case managers to increase the program because our goal is to reach as many women in Worcester as possible.
Every other program that is non-Healthy Start has a very small limit of how many women they can enroll.
We're able to reach more women that they're not able to provide services to.
But then we make sure that we're always referring clients to each other, our case managers work very closely with the outreach workers or other employees of other agencies to not overlap and duplicate services but provide the best service possible to the client.
So I think that really has helped a lot to reduce this feeling of competition.
To acknowledge I think that as a real issue in many areas, I think the competition often comes in relation to applying for more grants because all of the agencies want more grants and are all applying for the same thing.

That's why we try to do as much as we can to collaborate and then all be involved in it together.

DAVID de la CRUZ: Great.
For each of your projects you both have mentioned and talked a little bit about the different areas of the city that you work in.
How do you -- how many sites do each of you -- are each of your projects in and how do you get data compliance from each of these different sites?

JULIE WISNIEWSKI: We have five sites.
Four subcontracted and then the fifth is our lead agency.
We work very closely -- in fact, we have monthly meetings and as part of the section of the meeting is set aside to work on data issues, whether we're noticing as we're data cleaning that there is a certain pattern of mistakes or problem areas, we work on that at the same time.
I am always very available and will do one-on-one meetings at sites to work with them on it.
It's very hands-on.
We try to be extremely supportive because this is such a key element to our program.
But yet we also need to take a very strong stance that this is absolutely essential for your funding if you want to continue to be paid, you need to be giving us this data because oftentimes -- I think maybe Goldie alluded to this, the emphasis is much more on they want to be providing the service and that is the first important step and essential but we can't be able to continue this program without proving if it's working or not so we try to come back to that.

GOLDIE WATKINS BRYANT: David, there are two additional Healthy Start sites in the city but they're independently funded and we provide all of our services on-site so our staff are hired by us and report to us.
So we don't have that challenge.

DAVID de la CRUZ: Okay.
Great.
Thank you.
Let's -- I think we've been on long enough.
Let's wrap this up.
Before we go, if each of you would again give your email and contact information.
There have been a couple of requests for those again in case they have other questions once we hang up.

JULIE WISNIEWSKI: Is it possible to show on the webcast again my slide number 19?
That has my contact information.

My email has my name in it which is a difficult name so it's easier if you can see it visually.
My phone number is 508-854, 2124, Julie Wisniewski.

GOLDIE WATKINS BRYANT: For Goldie Watkins-Bryant the agency's email address is a part of the mailing we send to you in terms of our program monitoring tool.
But be that as it may if you would like to reach me directly my email address is health promoter at AOL.com.
And the number is 212-665-2600, extension 324.

DAVID de la CRUZ: Thank you.
I see now that the slide for Julie's contact information is up also.

JULIE WISNIEWSKI: Great.
Thank you.

DAVID de la CRUZ: This concludes our second webcast.
Please stay tuned for information that will be sent out soon on our third webcast that will occur later this summer probably sometime either at the end of August or the beginning of September.
We also remind you to keep an eye out for more information about the upcoming grantee meeting which will be September 21 through 24 in the Washington, D.C. area.
Actually at the Renaissance hotel.
More information will be sent out soon.
Thank you again.
I appreciate all of you participating in this webcast.
In particular Goldie and Julie.
And I encourage all of you to complete the online evaluation that will pop up when you close out of this webcast.
And give us your comments and any sort of feedback.
It will help us make future broadcasts much better.
Thank you again and we'll be in touch soon, bye.